TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-17-3221-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $105.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the billing edits for these procedures, and determined that CPT code 73030 is included with the primary CPT code for reimbursement. Consequently, the ancillary codes are included in the primary procedure reimbursement and are not eligible for separate reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2017	73030	$105.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment of the payment status indicator determines the service is packaged or excluded from payment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $105.54 for Code 73030 – "Radiologic examination, shoulder; complete, minimum of 2 views" rendered on February 3, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.403 (b) (3) and (d) states in pertinent parts,

   > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > and
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Review of the service in dispute finds;

   - Procedure code 73030 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.

     The medical bill contained submitted code 99285 which has a "V" status indicator and code 96374 with an "S" status indicator. Based on the applicable Medicare payment policy the carrier's denial is supported.

2. The total recommended reimbursement for the disputed services is $1,178.66. The insurance carrier has paid $1,377.42 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.